TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Pain and Recovery Clinic - North

Respondent Name
Starr Indemnity and Liability Company

MFDR Tracking Number
M4-16-3635-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
August 5, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our facility has been having difficulties with the above carrier in processing these authorized services which were denied for services not documented in the patient's medical records."

Amount in Dispute: $875.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This will confirm a payment of $823.75 was issued for d.o.s. 4-25-16 in regards to the attached above mdr."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 25, 2016	Chronic Pain Management	$875.00	$20.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - B12 – Services not documented in patients' medical records.
   - BL – This bill is a reconsideration of a previously reviewed bill. Allowance amounts do not reflect previous payments.
   - V093 – Clinical Validation Reduction Based Upon Review of Documentation Submitted.
   - No reduction available.

- ZD86 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Are the insurance carrier's reasons for reduction of payment supported?
2. What is the maximum allowable reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason codes B12 – "SERVICES NOT DOCUMENTED IN PATIENTS' MEDICAL RECORDS," and V093 – "Clinical Validation Reduction Based Upon Review of Documentation Submitted."

   Applicable 28 Texas Administrative Code §134.204(h)(5)(A) states:

   > Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.

   Review of the submitted information finds that the requestor billed for 7 units of a chronic pain management program. Submitted documentation supports performance of 6 hours and 45 minutes. The insurance carrier's reasons for reduction are supported. The division will review the MAR based on the documented time.

2. Per 28 Texas Administrative Code §134.204(h)(5)(B):

   > Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

   For documented 6 hours and 45 minutes, the MAR for the services in question is $843.75.

3. The insurance carrier paid $823.75 per Explanation of Review dated July 27, 2016. This amount is $20.00 less than the MAR amount. Therefore, an additional reimbursement of $20.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $20.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $20.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	September 28, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.